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Sally Pederby
Southern African Migration Programme

Natalya Dinat
Southern African Migration Programme

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Sally Peberdy and Natalya Dinat

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EDITORIAL NOTE

The names of the informants whose work history is presented in the vignettes are not provided for reasons of confidentiality and anonymity. In addition, certain small changes have been made to their accounts (e.g. places of origin) to prevent identification.

EXECUTIVE SUMMARY

South Africa is in the middle of a well-documented HIV/AIDS epidemic. Infection rates were calculated to be 22% of the adult population in 2003. A number of different reasons have been advanced to explain the HIV/AIDS epidemic in South Africa. They include poverty and economic marginalization; differing strains of HIV; and high rates of sexually transmitted diseases. However, migration patterns in Southern Africa have also been identified as one of the keys to understanding the high rates of infection in the region. Male migrants have been the focus of research on the relationship between HIV and migration. In the same way that the vulnerabilities of migrant women to HIV have thus far largely remained unexplored, the lives of migrant women have also received far less attention than the lives of their male counterparts.

This study examines the migrant and health experiences of domestic workers in Johannesburg, as well as some of their points of vulnerability to HIV. In 2004, domestic work was the second largest sector of employment for black women in South Africa. And, as this study shows, a defining characteristic of domestic workers in Johannesburg is their status as migrant workers. Given the importance of domestic work for women workers in South Africa, and the potential for their working conditions to affect their access to health care and their vulnerability to HIV infection, the study explored questions around migrancy, working conditions, access to health care and the experiences of, and vulnerability to HIV of domestic workers working in Johannesburg. The study is based on interviews with 1,100 female domestic workers employed in the City of Johannesburg.

A defining feature of the lives of this cohort of domestic workers was that they were overwhelmingly migrant workers; over 86% had a home outside Johannesburg and over 70% of those with other homes really wanted to be living there. Three-quarters of those with other homes had been working in Johannesburg for more than five years. The majority were from South Africa, and only 6% of the sample came from other countries, all in the SADC.

Another defining characteristic of the lives of domestic workers related to their migrant status was separation and isolation. Although the majority of the women interviewed were aged between 21 and 50 years, over 40% identified themselves as single, widowed, divorced or separated. The majority of those with long-term partners or husbands lived apart from their partners and children. Only a quarter of respondents lived with their long-term partner or husband. Over two-thirds lived on their employers' property. Most of these women were not

allowed visits from their families and friends. Their friends were mainly other domestic workers, neighbours and other church members.

Their working lives were hard, as many employers were not even meeting the minimum standards of employment set out by the Department of Labour. The majority of the sample worked for one employer (88%) and almost 45% worked six or seven days a week. Most worked between eight and ten hours a day. Their incomes do not reflect their long working weeks. Although over half earned between R501 and R1000 per month, over a fifth earned less than R500 per month.

Despite their working conditions, the women did not report problems accessing health services when they got sick. Those who had used health services overwhelmingly used allopathic government clinics and hospitals. Almost a third had used family planning services in the previous year, almost half had visited a clinic, and almost a third a doctor. Only 15% had chosen to visit a traditional healer. Of these, over a third had gone for non-health related matters.

Although almost half of the sample were single, only 10% had not had a sexual partner in the past five years. Since only a quarter of those with long-term partners or husbands actually lived with them, opportunities for either partner to have other sexual partners are magnified, and provide opportunities for potentially risky behaviour. These women experienced similar levels of violence in and outside their relationships as other women in South Africa. Almost a fifth had been pushed, shoved, slapped or had things thrown at them in the previous year, 6% had been raped, and 6% forced to have sex by their partner when they did not want to. Violence, rape and coercive sex all increase the vulnerability of women to HIV infection.

Another defining characteristic of this group of women was the lack of condom use. Over 60% of the sample had never used a condom in their lives. But, only 12% did not know where they could get free condoms. Also disturbing is that the majority of those who used condoms used them irregularly with only a fifth of condom users saying they used condoms all the time.

One of the reasons for low condom usage could lie with the low levels of knowledge around HIV/AIDS issues among these women. Almost a third were unable to describe how to have safe sex. Levels of knowledge around antiretroviral treatment and other HIV/AIDS related issues were also low. Only 16% knew about anti-retroviral therapy. Low levels of condom usage could also reflect perceptions of vulnerability, as only 11% said they thought they might have been infected. Less than a third had been tested for HIV and only 26 of the women interviewed had tested positive.

Low levels of knowledge and condom use appear to be largely

unchanged by the experiences of the women with the virus. Over a third knew someone who had died of AIDS, a similar proportion had a member of their family who was HIV positive, and almost a fifth had physically cared for or supported someone with AIDS.

Overall, it seems that migrancy and work shape these women's lives and affect their vulnerability to HIV. For many, particularly those who live in or on their employers property, their social lives are restricted by their working and living conditions. This social isolation may protect domestic workers as it reduces opportunities for starting new relationships. Conversely, their migrant status, separation from partners, and for many, restrictions on when and where they can see their partners and boyfriends, may make them more vulnerable.

Low levels of condom use, given the circumstances of their relationships, and low levels of knowledge around issues related to HIV/AIDS are of concern. The majority of these women look to television and listen to the radio to get infomation. The majority attend health services at some point during the year. Therefore, it seems that this cohort of women workers in Johannesburg are not being reached by health promotion campaigns relating to HIV/AIDS education, prevention and treatment.

INTRODUCTION

Women across Johannesburg spend their working day alone, a few perhaps in the company of their employer. And when they end their long day of work, many are still alone, separated from their partners, children and friends. Sometimes this separation is because they or their partners are migrant workers, other times it is because their friends and family are not allowed to spend time with them where they live. These women are Johannesburg's domestic workers. They live their lives against the backdrop of a devastating HIV/AIDS epidemic.

Southern Africa is experiencing the highest rates of HIV infection on the African continent. South Africa has the fifth highest rate of HIV infection in Africa and the world (Table 1).

Table1: Countries with Highest Rates of HIV Prevalence

Region	Country	Prevalence (%)
Southern Africa	Swaziland	38.8
Southern Africa	Botswana	37.3
Southern Africa	Lesotho	28.9
Southern Africa	Zimbabwe	24.6
Southern Africa	South Africa	21.5
Southern Africa	Namibia	21.3
Southern Africa	Zambia	16.5
Southern Africa	Malawi	14.2
Central Africa	Central African Republic	13.5
Southern Africa	Mozambique	12.2
East Africa	Tanzania	8.8
Gabon	Central Africa	8.1
West Africa	Cote d'Ivoire	7.0
Central Africa	Cameroon	6.9
East Africa	Kenya	6.7
East Africa	Burundi	6.0
Caribbean	Haiti	5.6
West Africa	Nigeria	5.4
Southern Africa	Congo	4.9
Central Africa	Chad	4.8

Source:http://hdr.undp.org/statistics/data/indic/indic_69_2_1.html

A number of different reasons have been advanced to explain the general picture of HIV/AIDS in South Africa including its rapid spread, high prevalence and uneven distribution. They include poverty and economic marginalization; differing strains of HIV; high rates of sexually transmitted diseases; and patterns of sexual contact.[1] However, migration patterns in Southern Africa are seen as one of the keys to understanding the high rates of infection in the region.[2] Epidemiological work has emphasized the role of migrancy and mobile workers in the spread of HIV.[3] The increased risk of migrants and their partners to HIV infection has been attributed to their living and working conditions as well as the shape of pattems of internal and cross-border labour migration.[4] Recent work has shown that migrants are not simply vectors of the disease. Rather, a complex set of conditions has evolved in the social and working lives of migrants which have had an impact on the epidemiology of HIV and the vulnerability of migrant workers to HIV.[5]

Male migrants, and particularly mineworkers and truck drivers, have been the focus of research on the relationship between HIV and migration.[6] At times their partners – usually called "women at risk" – have been included in research. Others have started to look at the sexual activities of women "left behind" by their migrant male partners.[7] Yet, little attention has been paid to the vulnerability of female migrants themselves to HIV infection and their access to health care and treatment.

The lives of migrant women have generally received far less attention than their male counterparts. So, despite the long history of women's internal and cross-border migration, the stories and lives of women migrants have remained largely undocumented.[8] Available evidence suggests that domestic work has traditionally been, and remains, a significant area of employment for internal and cross-border female migrant workers.[9]

Domestic work, although often characterized as "atypical work" in the service sector, provides significant opportunities for employment for black women in South Africa. In 2004, it was the second largest employment sector for South Africa's black female workforce, employing some 755,000.[10] Census 2001 found that work in private households is the largest source of employment for black South African women in Johannesburg with 88,000 women so employed (31% of employed black women). The census found that 42% of black women from the SADC who live in Johannesburg work in private households, although they comprise only 4.9% of women working in private households in the city.[11]

Many domestic workers, particularly those who live on their employers' premises, are migrant workers. They endure poor working

conditions and low incomes despite attempts by the Department of Labour to set minimum standards. Many live in isolation on their employers' properties and lack opportunities for collective action to improve their working conditions. Low incomes and arduous working conditions mean that access to health services may be limited as time away from work may mean lost income. Domestic workers could be at increased risk of HIV infection as a result of their gender, migrancy, social isolation, poverty, low levels of education, lack of access to health care services, and lack of power at work and possibly at home.

This study explores the vulnerability of domestic workers working in Johannesburg to HIV/AIDS.[12] Following a brief overview of the methodology, the report explores the migrant status of these workers. It then moves on to identify their demographic profile before looking at their working lives. It concludes with an exploration of their health status; access to and use of health care services; use of condoms in relationships; knowledge of HIV/AIDS; and attitudes to, and experiences of, being tested for HIV/AIDS.

THE SURVEY

The survey was undertaken in the Johannesburg Magisterial District in the City of Johannesburg. Input was solicited from the City of Johannesburg HIV/AIDS Unit, Gauteng Department of Health, the Department of Labour, the Domestic Workers Union and COSATU. Individual workers were consulted as the research instrument was being drawn up, and a pilot study was undertaken to test the instrument. Ethics approval was obtained from the University of the Witwatersrand prior to undertaking the study.

A sample of 1,100 female domestic workers was identified using a cluster sampling technique from 94 randomly selected census enumeration areas in the Johannesburg Magisterial District.[13] The Johannesburg Magisterial District (JMD) was chosen after examining the Labour Force Survey, which indicated that most areas lying outside the JMD, but which lay inside the boundaries of the City of Johannesburg, reported extremely low rates of employment of domestic workers.[14] In effect, this meant that Soweto was excluded from the survey. However, the random sample of enumeration areas included suburbs in the JMD from north to south and east to west and included a range of suburbs from Linksfield Ridge in the north west of the city to Eldorado Park in the south east.

The random selection of enumeration areas included only those areas with average household monthly incomes of over R2,500 and

which had more than forty households living in detached, semi-detached or town houses.[15] The income level was chosen in order to exclude households less likely to be able to afford to employ domestic workers. Owing to financial constraints, it was not possible to employ rigorous random sampling techniques in the flatlands of Johannesburg and these were also excluded. Therefore, all enumeration areas lying in Soweto, areas with average incomes of less than R2,500 per month, areas with less than forty households living in houses and domestic workers employed by flat dwellers were excluded from the survey.

Households to be interviewed were then randomly selected from the selected enumeration areas. On average 11.6 domestic workers were interviewed per enumeration area. An average of 16.8% of domestic workers in selected households in each enumeration area could not be contacted, despite repeat visits on different days and at different times. Fieldworkers recorded a refusal rate of 18.3%. Fieldworkers were instructed that they could not undertake the interview if the employer was present. However, employers who were at home when fieldworkers called were largely supportive of the study and excluded themselves from the interview. Following the interview, all participants were provided with a list of clinics in the area where health care is available, as well as HIV/AIDS-specific services available in the city.

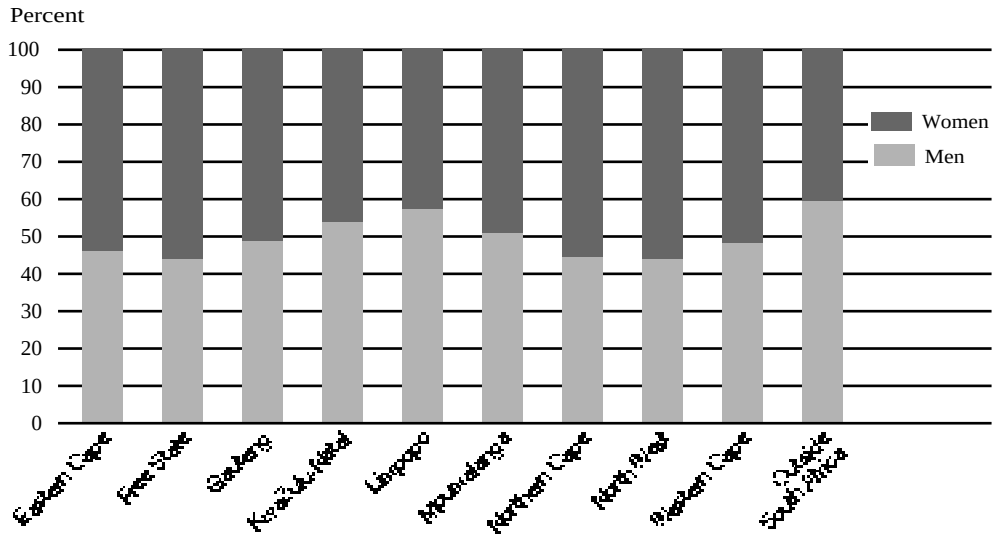
Given the various exclusion criteria, it is not possible to say whether the sample was representative of the total population of domestic workers in Johannesburg. However, it is possible to say that this study provides a population profile of domestic workers employed in houses in Johannesburg in areas with average incomes over R2,500. It is possible, given the focus on domestic workers in houses, that there is an over-representation of women who live-in and who work full-time for a single employer.[16]

JOBS FOR MIGRANT WOMEN

Johannesburg is the largest city in South Africa. In 2001 over 3,225,000 people were counted in the Census. The city is also home to the largest number of migrants of any city in South Africa. Census 2001 found that 35.2% of the population of Johannesburg were internal migrants and 6.7% were cross-border migrants or were born outside South Africa.[17] When people think of migrant workers, they usually think of male migrants, yet women have a long history of migration to Johannesburg. If place of birth is used as a marker of migrancy, Census 2001 shows that in Johannesburg, women constitute a significant number of migrant workers in the city. In the case of some provinces (Eastern Cape, Free State, Northern Cape,

Northwest and Western Cape) women migrants exceed the number of men (Figure 1).

Figure 1: Population of Johannesburg by sex and place of birth (%), 2001



Source: Statistics South Africa, Census 2001, 2004.

Domestic work provides significant employment opportunities for black female migrant and non-migrant women in Johannesburg. Census 2001 shows that work in private households provided employment for over 88,000 black women (or 31% of black women in formal sector employment). The census also shows that domestic service was the largest sector of employment for black South African women who had moved to Johannesburg from other provinces and other countries.[18]

One of the defining features of participants in this study was that the overwhelming majority were migrant workers. So, although over 50% of participants called the Johannesburg area home, some 86% said they had another home somewhere else (Table 2). Participants with homes elsewhere showed strong ties to their other homes. Of those with other homes, 72% said they would rather be living there if the same job and working conditions were available (Table 2). Although less than 10% visited their other home more than once a month, nearly 90% visited at least once a year (Table 3). Opportunities to visit their other home may be constrained by cost, distance and time.

It is sometimes assumed that cross-border migrants from SADC countries constitute a significant proportion of domestic workers in the city. However, this study, together with Census 2001, suggests that the overwhelming majority of migrant domestic workers are internal

Table 2: Domestic Workers as Migrants (%)			
	Total non-South Africans	South African migrants	Total sample
Call the Johannesburg area home (N=1100)	51.5	44.3	52.2
Have a home somewhere else as well (N=1100	98.5	100.0	86.1
Would move home if could have same job there (N=945)	58.2	72.8	71.9

Table 3: Frequency of Visits Home (%)			
	Total non-South Africans	South African migrants	Total sample
More than once a month	1.5	7.2	6.8
Once a month	0.0	17.7	16.5
Once every few months	7.5	26.1	24.7
Once or twice a year	67.2	39.4	41.4
Less than once or twice a year	6.0	6.4	6.3
I have been just once	4.5	0.9	1.2
I have not been home yet but I would like to	7.5	1.6	2.0
Never - I cannot return home	4.5	0.2	0.5
Never - I have no desire to return home	0.0	0.3	0.3
N=945			

migrants (Table 4). Only 68 (6%) of the sample were not South African citizens. When asked about the location of their other home, 6% said it was in another country. Of those who had homes in other countries all were from SADC countries. Almost 50% of foreign domestic workers came from Lesotho, almost a third from Zimbabwe and the rest were from Mozambique (6%), Botswana (4%), Swaziland (4%), Malawi (4%) and Zambia (2%).[19]

The majority of migrant domestic workers had grown up in rural areas, particularly those from other countries (Table 5). However, many had lived in an urban area for some time. Over three-quarters had lived in Johannesburg for five years or more (Table 6).

Unemployment seems to have been a significant motivator for moving to Johannesburg. Almost 70% were unemployed before they left home for Johannesburg (Table 7).

Patriarchal structures are often thought to have influence over the decisions of women in the household. Yet, when asked who made the final decision to go to Johannesburg, over three-quarters said they had made the decision to make the move themselves (Table 8). Few said

Table 4: Place of Birth and Place of Other Home (%)		
Province	Province of other home (survey)	Place of birth of black women in Johannesburg (Census 2001)
Gauteng	16.3	22.5
Eastern Cape	12.2	10.5
Free State	12.1	9.4
KwaZulu-Natal	10.9	10.9
Limpopo	10.5	15.9
Mpumalanga	6.2	5.2
Northern Cape	3.2	1.5
North West	20.4	17.9
Western Cape	1.1	1.3
Other country	6.0	5.0

Table 5: Place of Growing Up (%)					
	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
A major city	1.5	0.2	4.6	0.9	0.9
A town	4.4	1.3	6.6	2.0	2.2
A township/location	17.7	26.3	69.5	32.7	31.7
A small town	2.9	2.6	0.7	2.3	2.4
A rural settlement/village	60.3	51.6	11.9	45.8	46.6
A rural farm	13.2	18.0	6.6	16.3	16.2
N=1100					

Table 6: Length of Time in Johannesburg (%)		
	Total non-South Africans	South African migrants
Less than one year	5.9	4.9
1 year	8.8	2.7
2 years	4.4	5.5
3 years	8.8	4.8
4 years	5.9	4.2
5 years	7.4	8.0
More than 5 years	57.4	69.9
N=943		

Table 7: Employment Status Prior to Coming to Johannesburg (%)		
	Total non-South Africans	South African migrants
Employed	19.4	23.6
Unemployed	70.2	68.7
Self-employed	3.0	0.8
Student/scholar	4.5	6.3
Other	1.5	0.3
N=943		

that family members discouraged them from leaving for Johannesburg. Only 5% of non-South Africans and 3% of South African migrants met with opposition to their move.

Table 8: Decision Making About Going to Johannesburg (%)		
	Total non-South Africans	South African migrants
Myself	77.6	77.5
My partner/spouse	6.0	5.1
Mother	7.5	7.3
Father	0.0	1.8
Uncle	0.0	0.6
Aunt	0.0	0.6
Brother	0.0	1.0
Sister	4.5	3.2
Other	1.5	2.9
N=944		

Almost three-quarters of the domestic workers had a place to stay in Johannesburg before they left home. Very few (less than 15%) did not know anyone in the Johannesburg area before they made their move (Table 9). The majority already had family members in the city.

Table 9: Knowledge of People and Places of Stay (%)		
	Total non-South Africans	South African migrants
Had a place to stay in Johannesburg (N=942)		
Yes	73.1	71.6
Knew people in Johannesburg (N=940)		
No	12.0	12.5
Yes, family members only	59.7	66.4
Yes, friends only	22.4	17.0
Yes, family members and friends	3.0	3.4
Employer	0.0	0.1

The majority of non-South African migrant workers seem to retain relatively strong ties with their home countries as 88% regularly send money and goods to their home country. Not surprisingly, the main reason they came to South Africa was to find a job. The choice of South Africa may have been influenced by family experience and contacts as over half said their parents had worked there and a third said their grandparents had worked there.

In terms of legal status and the method of entry, only two of the women had walked across the border to enter South Africa. The rest travelled by taxi, bus, train and car. A third of the foreign domestic workers said they were scared of being deported for not being South African. However, this could reflect fears of over-zealousness on the part of the police and the Department of Home Affairs and not illegal status per se.[20] Ten percent of the non-South African respondents had been arrested for being foreign. Three had been detained but only two had actually been deported. Nearly 40% of the SADC nationals had South African ID books. Many had lived in South Africa for over five years and a quarter said their partner was South African, so it is probable that these were legitimately obtained.[21]

Beside their fears of being arrested or deported, some women had negative experiences in South Africa. Ten had been harassed for being a foreigner. Three said the police or other government officials had assaulted them for being non-South Africans. Five had been assaulted and ten robbed since they had been in the country. Two had been raped when they were living in South Africa. One said a government official or policeman had sexually assaulted her on account of her nationality.

Although being a foreign worker has negative impacts on the lives of some domestic workers, it does not seem to have had a significant impact on their access to health care. Only four said that being a foreigner had stopped them from seeking medical treatment in South Africa. Fifty-four (80%) had used govemment health services and thirty-one (55%) had used private health services. None had been refused treatment for being a foreigner, although five said they had been treated differently.

DOMESTIC WORKERS IN PROFILE

Who are the women who scrub the homes of the city and ensure that families leave their homes pressed and clean? The majority are of an age when people already have or are establishing long-term relationships and developing families. Respondents were mostly aged between 21 and 50 years (Table 10).[22] The overwhelming majority (almost 60%) were aged between 31

and 50. Five of the workers interviewed were under twenty years in age, while 35 were still working when they were over 60. Non-migrants tended to be older than migrants. Some 64% of the former were over 40 years old compared with 38% of foreigners and 49% of internal migrants.

Table 10: Age on Last Birthday (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
15-20 years	0.00	0.34	1.32	0.49	0.5
21-30	25.0	20.5	13.3	19.4	19.8
31-40	36.8	30.4	21.2	26.1	29.6
41-50	22.0	29.3	39.1	30.7	30.2
51-60	10.3	16.4	21.5	17.2	16.6
Over 60	5.9	3.0	3.3	3.0	3.2
N=1100					

The women live solitary lives marked by separation from family members. Although 58% had a husband or partner, more than half were temporarily living apart from them. So, only 27% of the women interviewed were living with a spouse or partner. Some 26% were single and 16% divorced, separated or widowed (Table 11). A third of the married women and 60% of those with partners were not living with them.

Table 11: Marital Status (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Single	27.9	24.8	29.1	25.5	25.8
Divorced/separated	7.4	7.0	7.3	7.0	7.0
Widowed	8.8	8.3	13.9	9.1	9.1
Married but temporarily living apart	5.9	6.2	3.3	5.7	5.8
Married and living together	11.8	9.6	15.9	10.5	10.5
Living with partner	14.7	17.1	16.6	17.0	16.8
Partner but temporarily living apart	23.5	27.0	13.9	25.1	24.9
N=1100					

Many women are forced to live apart from their partners and spouses in their working and living arrangements. Almost 45% were not allowed to have a partner stay with them where they were living,

because of restrictions imposed by employers. Some 17% of non-migrants were temporarily living apart from their partners suggesting their partners are migrant workers.

The majority of the 378 women who were temporarily living apart from their partners and spouses saw them fairly frequently (Table 12). Some 64% saw them more than once a month, and 14% once a month. Some 9% saw them only once every few months, 8% once or twice a year. However, 4% said they saw their partner less than twice a year, while four women said they never wanted to see their partners again.

Table 12: Frequency of Contact with Partners (%)

Frequency of contact	Percentage (%)
More than once a month	63.5
Once a month	13.8
Once every few months	8.9
Once or twice a year	7.7
Less than once or twice a year	4.0
Never	2.2
N=378	

Almost 70% of the women had children, but were likely to live apart from them. Non-migrants were more likely to be childless (42% compared to 28% of migrants), but were also more likely to live with children (52% compared to 13% of migrants). Overall, less than 20% lived with their children.[23] Almost a third said their children were not allowed to stay with them where they lived, because of restrictions imposed by employers.

Although many domestic workers live alone, separated from their partners and children, this does not mean that they do not have family responsibilities. Almost 95% were financially supporting other people in full or in part. The majority of dependents were their own children. Other financial dependents included parents, siblings, grandchildren and nieces and nephews and their partners.

Domestic work is often considered to be low-skilled and new entrants to the sector do not usually have to meet educational entry requirements. Certainly, this survey confirms that domestic work provides employment for women with low levels of education.[24] Almost one-third had no schooling or only some primary education (Table 13). A further 16% had completed primary school, while over 40% had been to secondary school. Literacy levels are important as they not only affect employment opportunities, but also may affect access to health information as well as peoples' ability to deal with bureaucracies and employers.

Table 13: Level of Education (%)	
Level of education	(%)
No formal schooling	13.3
Some primary education	27.0
Completed primary education	16.4
Some secondary education	42.9
Tertiary education	0.3
Don't know/not answered	0.2
N=1100	

VIGNETTE

Mrs A is a woman in her mid-fifties. She is married but lives apart from her husband and children when she is working in Johannesburg. She has four children aged 23,18 and twins aged 13 years who stay with her husband, their father, in another province. She takes money home with her to support the family when she goes to visit them every month. Her partner and children cannot stay with her where she lives.

The child of farmworkers, she grew up on a farm and was unable to finish primary school. She has only just arrived in Johannesburg where her husband, a mineworker, was recently retrenched. She says she is definitely only in Johannesburg for the work and would go back to live at home if she could find a similar job there. She has worked for her employer for less than six months. She works hard, seven days a week, and all the hours the family are awake. It is difficult for her to take time off. She earns between R500 and R1000 per month. Mrs A has accommodation on her employers' property and does not have to pay rent. Unlike many of her fellow domestic workers, she has access to a bathroom with hot and cold running water where she lives, but that is because she lives in the same house with her employer. She can use her employer's phone, but cannot make private phone calls. Mrs A has no medical aid or pension scheme, but she does pay R50 a month to a stokvel. Although Mrs A is a new arrival in Johannesburg she does have relatives she can turn to for help, advice and support and meets them usually once a week either at their home or her home. Although she has relatives and other friends she feels lonely most of the time because she misses her children and husband in the Free State. Dreaming of the big win, Mrs A plays

lotto, fafee and scratch card competitions. Her health is relatively good, although she has problems with high blood pressure. She doesn't smoke but takes snuff and occasionally has a drink. She has been to the clinic twice in the past year but otherwise has not visited any other health services. Mrs A does not want any more children and has been sterilized. Mrs A has only had the one partner in the past five years, her husband. She has not experienced physical violence in her relationship or outside it. She does have experience of HIV/AIDS and has at least one family member who is HIV positive. However, Mrs A does not know where she could go to get an HIV test for free although she would like one if she knew where to go. However, she does know where to go to get free condoms and unlike many of her fellow workers, Mrs A has used condoms and uses one regularly with her husband. Although Mrs A knows that she needs to "condomize" when having sex with her husband, she was unable to explain any issue relating to HIV/AIDS when asked – but she says she does talk about it with her children.

Differences in educational levels were related to where a person grew up (Table 14). Women from Mpumalanga (47%), the North West (45%) and the Northern Cape (46%) were most likely to have little or no education. Workers from Gauteng, Limpopo, the Eastern Cape and other SADC countries were most likely to have been to secondary school.

In sum, this demographic profile of domestic workers in

Table 14: Level of Education by Place of Origin (%)

	No schooling	Some primary	Completed primary	Some secondary	Tertiary
Gauteng	13.9	25.0	8.3	52.8	0.0
Eastern Cape	23.1	13.4	20.9	38.2	0.8
Free State	9.8	17.9	19.6	36.8	0.0
KwaZulu Natal	12.5	30.0	15.0	40.8	0.0
Limpopo	10.4	22.6	13.9	52.2	0.9
Mpumalanga	19.1	27.9	14.7	38.2	0.0
Northern Cape	13.5	32.4	13.5	40.5	0.0
North West	17.7	27.2	14.3	40.6	0.0
Western Cape	0.0	41.7	16.7	41.7	0.0
Other Country	12.2	13.6	21.2	53.0	0.0
Total	13.2	26.0	16.3	44.1	0.2
N=1100					

Johannesburg indicates that many live on their own, and even those with partners and children are likely to live apart from them. Their lives are shaped, at least in part, by their profession as well as their migrant status since where they live prevents them from living with their partners and children. Their choice of profession may be shaped by their low level of educational attainment which may restrict their job opportunities.

WORLDS OF WORK

The South African government has recognised that the working conditions and incomes of many domestic workers are poor. To that end it has made efforts to improve and formalise the working conditions of domestic workers. At the time of the study, the official minimum wage for domestic workers employed in urban areas and working more than 27 hours per week was R4.87 per hour or R861.90 per month. For those working 27 hours or less per week the minimum wage was R4.87 per hour or R569.79 per month.[25] Maximum working hours have been set by the Department of Labour at 45 hours per week plus ten hours of overtime (nine hours per day for those working 1-5 days per week and eight hours a day for those working 6-7 days per week).[26] As of October 2003, employers of domestic workers have to make contributions to the Unemployment Insurance Fund for their employees.

WORKING CONDITIONS

Even the minimum standards set by the Department of Labour do not guarantee that the working conditions of domestic workers are easy. Certainly, the women interviewed for this study live hard lives, and work long hours for low pay. And, their responses indicate that many employers are not meeting the minimum standards of employment. The majority worked for one employer only (88%) and lived at the place where they worked (64%) (Table 15).[27] These responses may reflect the parameters of the sample.

Table 15: Number of Employers (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans
One	88.2	88.3	88.1	88.2
Two	10.3	9.1	9.9	9.2
Three	1.5	2.1	2.0	2.1
Four	0.0	0.6	0.0	0.5
N=1100				

VIGNETTE

Ms B is a single woman in her late 30s. Although unmarried, Ms B has two children aged 16 and 6 years. Her children live with her in Johannesburg. She has some secondary education. Ms B has been working for her employer for almost five years. She works five days a week and about 9 hours a day. She earns more than many other domestic workers as she makes between R1,500 and 2,000 per month, and receives food as part of her pay. She is not a member of a medical aid or pension fund, but does contribute R70 per month to a stockvel. Ms B does not live on her employer's property and travels to work by mini-bus taxi which costs her almost R290 per month. She rents a room in a house (for R300 per month) which she shares with her children. They do not have access to a bathroom with running water, but she can get water from an inside tap. Her house also has electricity. Ms B has always lived in the Johannesburg area but she does not have a strong network of friends close to where she lives. She mainly socializes at church, and says that although she rarely feels lonely she finds it difficult to meet people. She spends most of her leisure time watching television and listening to the radio – her two main sources of information.

Ms B is relatively healthy, but does have problems with high blood pressure. However, she does not smoke, drink, use snuff or take other drugs. She has been to the family planning clinic as she does not want to get pregnant again and uses the pill for contraception. Ms B has at least one family member who is HIV positive. Although she says she knows where to get an HIV test and would take one if it was offered in secret and for free, she has not taken an HIV test. She also knows where to get free condoms and knows how to protect herself when having sex, but has never used a condom in her life, even though she has had sex in the past five years.

The employment of domestic workers seems to be stable, or at least long-term. Over 40% of the women interviewed had been employed by their main employer for more than five years (Table 16). Non-South African migrants seem to have less stable employment, or were newer entrants to this sector of the labour market, as over 30% had been employed by their main employer for less than a year.

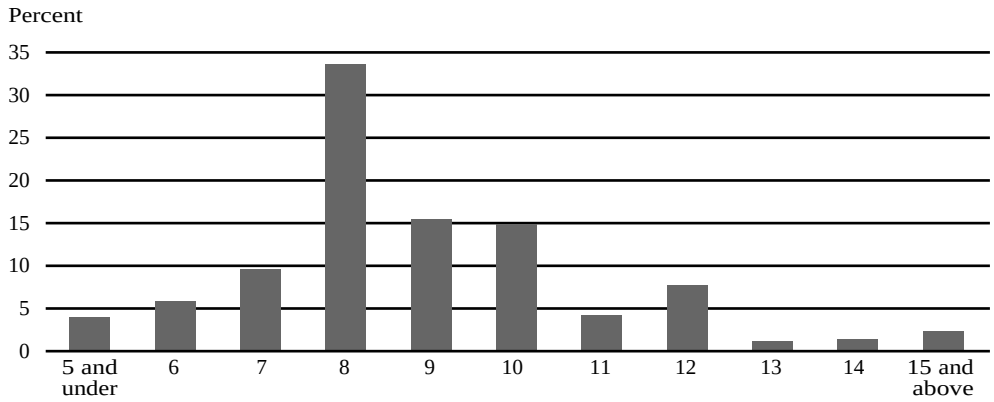
Table 16: Length of Time Working for Main Employer (%)					
	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Less than 6 months	17.7	13.4	10.6	13.0	13.4
More than 6 months and less than a year	14.7	8.4	15.2	9.4	9.7
1-3 years	30.9	26.9	23.8	26.4	26.7
4-5 years	4.4	9.7	12.6	10.1	9.8
Over 5 years	30.9	41.6	37.8	41.0	40.4
N=1100					

The working week and day of domestic workers tends to be long. People who work long hours and days for little pay can find it hard to access health care, particularly if taking time off to attend a clinic results in a loss of pay. On average, respondents worked 5.4 days per week (Table 17). Over 30% worked five days per week, over 20% worked a six day week, while almost 20% worked seven days per week. The data suggests that migrant workers worked the longest weeks and that non-migrant workers were most likely to work a five-day week.

Domestic workers work long days. Some 46% work nine hours or more per day and 31% work 10 hours or more per day (Figure 2). Some, it seems, never go off duty. Migrant workers, whether South African or foreign, are likely to work the longest days. A significant proportion of the employers were thus exceeding the maximum working hours set by the Department of Labour.

Table 17: Number of Days Worked (%)					
	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
1 day per week	10.4	7.9	9.9	8.2	2.8
2 days per week	5.2	9.4	10.5	9.6	5.9
3 days per week	7.8	7.8	10.5	8.2	7.9
4 days per week	5.2	2.8	6.4	3.3	3.7
5 days per week	32.3	29.5	34.3	30.2	34.7
6 days per week	16.9	23.7	17.4	22.8	25.9
7 days per week	18.2	17.2	7.6	15.7	18.5
Half a day per week	1.3	0.2	2.3	0.5	0.5
Other	0.00	0.10	0.6	0.2	0.1
N=1100					

Figure 2: Average number of hours worked per day (%)



A significant proportion of domestic workers appear to eam less than the minimum wage for urban areas as set out by the Department of Labour. As the majority of women surveyed worked more than 27 hours a week they should have been earning over R860 per month. Over 20% of respondents earned less than R500 per month, and just over 55% made between R501 and R1,000 per month (Table 18).[28] One elderly woman who lived at her employers property said she earned nothing, but was provided with food and accommodation. Almost 25% received some food as part of their pay, and 61% had free accommodation on their employers' property. Only 5% of the women had another source of income, which, on average, brought them a further R240 per month. Few who said they had children of eligible age said they received the child income grant.

Table 18: Monthly Income (%)

	Non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Less than R 100	0.00	0.3	1.3	0.5	0.5
R100-500	30.9	19.9	22.5	20.2	21.2
R501-1000	47.1	56.6	51.7	55.9	55.7
R1001-1500	14.7	18.0	19.9	18.3	18.1
R1501-2000	7.4	3.4	4.6	3.6	3.8
R2001-2500	0.0	0.6	0.0	0.5	0.5
R2501-3000	0.0	0.1	0.0	0.1	0.1
Not answered/ don't know	0.0	0.0	0.9	0.0	0.7
N=1100					

VIGNETTE

Ms C is almost forty years old. She has a partner and three children aged between 3 and 15 years. She lives with her partner, but her children stay in another province, two with her sister, and the other with his father. She sees her children about once a month. Ms C has been working eight hours a day, six days a week for the last five years. She earns between R501 and R1,000 per month. She also receives a child grant for her youngest child (then R150 per month). She is not a member of a medical aid or pension scheme but does make a R40 contribution each month to a stockvel. Ms C travels home to the room she rents (R500 per month) with her partner by mini-bus (R150 per month). When she gets home, she does not have access to a bathroom with running water and has to go outside to get water. Ms C came to Johannesburg from a village in her home province more than five years ago. And, although her current partner lives with her in Johannesburg she does not think of the city as home and would go back home to live if she could find a job there. Although Ms C wishes she could live there, she does have friends in Johannesburg. Her closest friend lives near her work and is also a domestic worker. She is able to see her often during the week. Ms C also socializes at work, in the street and her and her friends' homes. Her leisure time is mainly spent visiting friends or watching television and listening to the radio. The latter are where she gets her information. An optimistic woman, Ms C regularly plays fafee and the lotto. She has good health and has only been to the clinic for family planning as she does not want another child right now. She uses the pill for contraception. She has had a couple of relationships in the past five years. And, although she has used condoms and knows about safe sex, she finds that she uses them with some men and not others. It seems she uses condoms for contraception rather than for protection against HIV/AIDS or STIs. She has never used a condom when she has had sex with a man for the first time. Although she knows where to get an HIV test, Ms C does not want to be tested.

While it is difficult to draw definitive conclusions from the small sample of non-South African domestic workers, it seems that while most earn only R100-500 per month (31%), more earn over R1,500 per month than South African migrant workers (7% versus 3%).

Respondents were also asked about their long-tem financial security and savings. Only 24% were members of a pension plan. Contributions

to pension plans were made by employers (61%), themselves and their employer (18%) and on their own (8%). Some 40% were members of a stokvel, burial society or other kind of informal savings scheme to which they contributed an average R110 per month.

In terms of demands on their income, 94% had financial responsibilities for dependent children as well as other adults. On average the women supported just over 3 people. Some 79% provided financial support to their own children (on average 2.35 children).

VIGNETTE

Ms D is in her early thirties. She comes from Swaziland. She has one child (aged sixteen) who lives with her in Johannesburg. Ms D was not able to attend school when growing up, and became a mother when young. She has a South African partner who she sees regularly but he does not live with her. Ms D moved to Johannesburg from rural Swaziland over five years ago. She came to South Africa to find work, but also to find her father who had left for South Africa to work many years before and who never returned. The decision to move to Johannesburg was made by herself, but made easier because she had friends living in the city who could put her up when she arrived. Although she calls Johannesburg home, she would really rather be living and working in Swaziland. But, given her working conditions she only goes back to Swaziland once a year. As a non-South African, Ms D does not have an ID book but does not worry about being arrested or deported for being a foreigner. However she says she has been physically assaulted and sexually harassed by South African police and government officials for being a foreigner. Although she has used South African public health services, being a foreigner has stopped her from seeking medical treatment when she thought she needed it. Ms D says she works ten hours a day, seven days a week. She does not earn much for her work, only between R501 and R1000 per month with some food provided by her employer. While she has been living in Johannesburg for more than five years, she has only worked for her current employer for two years. She is not a member of a medical aid or pension scheme, but Ms D does contribute R80 each month to a stokvel. Although she does not earn much, she sends money and goods home at irregular intervals. Ms D walks to work from the one room shack she owns and lives in with her child. When she gets home, she has to walk off her property to the tap to get water. She has no access to a phone and no

electricity where she lives. Although she is not South African, Ms D does have friends. Her best friend is a neighbouring domestic worker and she also socializes with home-girls and other domestic workers. She is able to have her best friend visit her at least once a week. Church is where Ms D spends most of her limited leisure time. She also visits friends and listens to the radio. Perhaps reflecting the lack of electricity at home, Ms D gets most of her information from church. She is relatively healthy, but suffers from bad headaches for which she has been to the clinic and a traditional healer. She would like another child and has been trying for more than two years to get pregnant. Ms D has had five partners over the past five years, but is currently in a relationship with only one man. Although her partner apparently does not hit her, he has forced her to have sex when she didn't want to because she was afraid of what he might do if she did not. Although she does not personally know anyone with HIV she is worried that she may have been exposed to HIV through having unprotected sex. However, she says she does not want to be tested, even if the test was free and in secret. But even if she did, she does not know where to get a test. And, despite her fears, and that she knows where she can get free condoms, Ms D has never used a condom in her life. And, when asked, she did not know how she could protect herself from HIV and other STIs when having sex.

ACCOMMODATION

Almost two-thirds (64%) of the workers received accommodation with their jobs but few paid rent to their employers. The remaining 36% who had to pay for their own accommodation in Johannesburg, paid an average of R152 per month. Those who live away from their place of employment paid an average of R175 per month for transport to work.

So, if the working week of the majority of these women is long and hard, what do they go home to at the end of a long day of cleaning up after other people? The majority go nowhere but stay at their place of employment in accommodation provided by their employer (64%). Not surprisingly, migrant workers, but particularly South Africans (69%), were most likely to live on their employers' property. The slightly lower proportion of non-South African migrants living-in (62%) is probably because they were more likely to have been employed for a shorter time and to work part-time. Only 36% of non-migrants lived-in.

Table 19 shows the type of accommodation of domestic workers in

Johannesburg. While the majority lived at their employers, the remainder were most likely to live in shacks or rent a room. So, most of the domestic workers that left their place of employment at the end of the day went home to a shack (16%). Another 8% went home to a room. Overall, over two-thirds of respondents lived in just one room, and another 11.5% lived in two rooms (Table 20). Some of those who live in places with more rooms stayed inside their employers' houses. However, even if a domestic worker lives at their employers' property it does not necessarily guarantee good and healthy living conditions.

Table 19:Type of Accommodation (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Share a shack	4.4	1.8	1.3	1.8	1.9
Own a shack	14.7	13.9	18.5	14.6	14.5
Rent a room in a house or flat or above flats	11.8	7.8	9.9	8.2	8.4
Rent an apartment/ flat	4.4	0.8	2.0	1.0	1.2
Rent a house	0.0	1.3	6.0	1.9	1.8
Own a house/flat	1.5	3.3	21.2	5.9	5.6
Live on employers' property and pay rent	2.9	2.9	0.0	2.4	2.6
Live on employers' property and do not pay rent	58.8	65.3	36.4	61.0	61.2
Other	1.5	2.4	4.7	2.8	2.6
N=1100					

Table 20: Number of Rooms in Home (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
One	73.5	69.6	40.4	65.3	66.3
Two	2.9	11.4	15.9	12.1	11.5
Three	8.8	4.4	12.6	5.6	5.9
Four	1.5	4.1	12.6	5.3	5.1
Five	5.9	2.2	9.3	3.2	3.4
Over five	13.3	8.2	9.5	8.6	7.8
N=1100					

Having spent all day washing and cleaning for other people, only half of the women interviewed could go home to a bathroom with hot and cold running water. Over one third (37%) had no access to a bathroom with running water (Table 21). Only 51% had access to an inside tap for water; 39% had to use an outside tap and 10% had no access to water on the property where they lived. Most had access to electricity, however.

Table 21: Access to Facilities (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Access to bathroom with running water					
No access	32.4	36.8	39.7	37.1	36.7
Yes - hot and cold water	58.8	51.1	45.7	50.3	51.0
Yes – cold water only	8.8	12.1	15.2	12.5	12.3
Source of drinking water					
Inside tap	54.4	49.2	55.6	50.2	50.5
Outside tap (on property)	32.4	41.1	29.8	39.5	39.2
Tap off property	7.4	6.4	7.3	6.5	6.6
Water brought in containers	5.9	3.2	6.0	3.6	3.7
Electricity					
Yes available where live	80.9	83.4	82.8	83.3	83.3
N=1100					

They also had access to telephones to make contact with other people. So, although 12% had no access to a telephone land-line or cell phone, 39% could use a friend or their employers' land-line and 33% had access to a cell-phone. Using other people's phones meant that 28% could not make private phone calls.

These women clearly work hard for a living, toiling through long days. Many never leave their place of employment at the end of the day, and wherever they live conditions are not good. Their living and working conditions may not increase their vulnerability to HIV infection, but, if they are infected, have the potential to compromise their health.

VIGNETTE

Mrs E is a widow in her late 40s. She has not found another partner since her husband died. Growing up in a township in Limpopo she was only able to go to primary school for a short time. She has two children from her marriage, one aged twenty-three the other in his late teens. Mrs E provides financial support to both although they live in Limpopo. She goes home once a month to see them. And although she has lived in the city for more than five years and calls the Johannesburg area home she would rather be living in Limpopo if she could find similar work there.

Except for the weekends when she goes home, Mrs E says she works nine hours a day, six days a week. Despite her long hours and that she has worked for her employer for nearly five years she still earns less than R1,000 a month. She has no pension or medical aid plan but she does make a contribution of R100 a month to a burial society. Mrs E is provided with accommodation by her employer where she lives in two rooms. Unlike many of her fellow domestic workers, she has access to a bathroom with running water which she has to herself. Her rooms also have electricity so she can listen to the radio and watch television – her main leisure activities. She relies on the radio and newspapers for information. She is a hopeful person playing fafee, lotto and scratch card competitions regularly. Mrs E has family in Johannesburg who provided her with somewhere to stay when she first arrived. Although Mrs E would rather be living in Limpopo she isn't lonely in Johannesburg. As a regular churchgoer, she meets friends at church. Although otherwise in good health, Mrs E has problems with high blood pressure which mean that she has to attend hospital every month. And, although she doesn't drink or smoke she likes to take snuff. Mrs E does not want to become pregnant again and so she has been sterilized. Her life has been touched by HIV, as a family member who she cared for and supported has died of AIDS. Although Mrs E knows where to get tested for HIV and says she would take a test, she has yet to be tested. And, perhaps because of her personal experience caring for someone with HIV, Mrs E is extremely knowledgeable about HIV and AIDs. Although she has never used a condom, she was married to her husband for a long time, even if she did not live with him all the time, and has not started a new relationship since her husband died.

WORLDS OF LEISURE: A LONELY LIFE?

Many domestic workers live relatively solitary lives and are often isolated, even though they live in South Africa's largest city. This isolation in part reflects the location of their homes and workplaces in the suburbs of Johannesburg and the length of their working weeks and days, but it also reflects their migrant status.

Of the women interviewed, almost 30% of migrants and almost a quarter of non-migrants did not have any friends near where they worked. Despite their separation from family and friends, over half said they never felt lonely and only 16% felt lonely often or most of the time. The loneliest times for domestic workers were in the evenings and weekends. Again this may be because their living arrangements precluded them having friends (and, of course, partners and children) to visit. Almost half were not allowed to have visitors where they lived. Friends were primarily fellow domestic workers, other neighbours, and relatives and friends from home (Table 22). Sadly, and perhaps expressing the isolation of some of these workers, eight said their employer was their best friend. Finding friends in their neighbourhood meant that almost two thirds said they saw their most important friend three or more times a week.

Table 22: Most Important Friends (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Neighbouring domestic worker	26.9	27.6	22.1	26.7	27.0
Other domestic workers	15.7	7.5	7.8	7.5	8.0
Gardeners/local workers	0.9	1.0	0.4	0.9	1.0
Relative	16.7	21.2	23.8	21.6	21.0
Home-girl	16.8	17.3	12.6	16.5	17.0
Neighbours (within same street block)	13.9	19.3	27.3	20.6	20.0
Employer	1.9	3.2	3.9	3.3	3.0
Other	7.4	2.3	1.3	2.1	3.0
N=1478 (multiple responses)					

The social lives of domestic workers, like their working lives, are relatively constricted, at least for those who live-in. Most of their social activity (whether migrant or non-migrant) takes place in homes or at

church (Table 23), and very few regularly visited bars or shebeens.[29] And, despite the clusters of domestic workers often seen sitting on the grass verges of Johannesburg's northern suburbs, the street played only a small role in their social lives.

Table 23: Places Where Workers Socialise (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Shebeen/ bar	0.0	0.56	2.5	0.9	1.0
Church	22.4	23.85	25.2	24.1	24.0
Park	3.7	3.42	3.6	3.4	3.0
My home	26.1	24.51	27.2	24.9	25.0
Their home	26.1	24.18	26.0	24.5	25.0
Others' homes	5.0	5.39	4.1	5.9	5.0
Street	8.7	7.45	5.6	7.2	7.0
Shops	7.5	9.93	5.9	9.3	9.0
N=2675 (multiple responses)					

The main leisure activities for domestic workers when not working were watching TV and listening to the radio (49%), their two main sources of information. A further 14% spent time alone. Some 12% spent time with friends, and only 3% (or thirty three women) said they spent time with a male friend. Domestic workers do not seem to be big gamblers in their leisure time, with only 8% reporting that they had played fafee. However, dreams of big wins are not far away as almost half had played the Lotto in the previous three months.

WORLDS OF HEALTH

In South Africa, health care is available to South Africans through state services or private health care services. Citizens attending state facilities are required to pay fees and pay for medicines unless they are able to prove that they are unable. Non-citizens, if identified as such, may be required to pay higher fees and deposits for services provided by the state.[30] The policy of charging foreigners differential rates varies from facility to facility. Medical aid, or health insurance, will pay for health care treatment (if required, and according to the plan paid for) at private health facilities. Domestic workers, because of the long days they work, working conditions, isolated lives and low pay may have particular health problems, and may also have problems accessing health care.

HEALTH STATUS

Just over a fifth of respondents had taken a day or more off work in the previous three months due to ill-health. Non-migrants were more likely than migrants to have taken a day off work. Their illnesses may have prompted visits to the doctor as, overall, 20% had visited a clinic or doctor in the previous three months. Almost a hundred women (9%) had been admitted to hospital in the previous year.

Participants reported that they had been told by a doctor or nurse that they currently had specific medical conditions (Table 24). Some 12% (133 women) reported that they had been diagnosed with a sexually transmitted disease at some point in their lives. However, overall, their most significant health problems were related to work (joint, back and limb problems). Over 20% reported high blood pressure problems and over 5% that they had been diagnosed with heart problems. South African non-migrant women were most likely to have reported problems with their blood pressure and hearts.

Table 24: Diagnosed Health Problems %

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Sexually transmitted disease	-	-	-	-	12.4
Asthma	1.5	4.0	4.0	4.0	3.8
High blood pressure	14.7	20.8	29.3	22.0	21.5
Sugar diabetes	1.5	3.0	4.0	3.1	3.0
Overweight	1.5	2.4	3.3	2.5	2.5
Heart problem	4.4	5.6	5.3	5.6	5.5
Joint or bone or arm/leg/back problem	10.3	14.3	16.0	14.5	14.2
Infectious illness	2.9	3.4	2.0	3.2	3.2
Mental health problems	0.0	1.1	0.0	1.0	0.9
Tuberculosis	2.9	3.3	1.3	3.0	3.0
N=1096					

Domestic workers generally do not compromise their health through smoking, or find solace in alcohol or drugs (Table 25). Snuff seems to be the tobacco of choice, but less than 8% currently smoke cigarettes.

Table 25: Tobacco, Alcohol and Drug Use (%)					
	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Ever smoked cigarettes	8.8	10.4	17.2	11.4	11.4
Smoke now	5.9	7.0	11.3	7.6	7.7
Taken snuff in past three months	25.5	27.9	34.4	28.7	28.5
Taken alcohol in past four weeks	11.8	10.8	17.2	11.8	11.8
Taken dagga in past three months	2.9	0.2	2.7	0.6	0.7
Ever used mandrax, injected drugs or other drug	0.0	0.1	0.7	0.2	0.2
N=1100					

The 130 women who had drunk alcohol in the four weeks prior to the interview were asked how often they had had a drink. For most, having a drink was a weekend leisure activity. Some 60% of those who had used alcohol drank every weekend. Another third were occasional drinkers, having drunk alcohol on less than three days in the previous month. Only one respondent said she drank alcohol every day. Three others had a drink nearly every day. These four women were all long-term Johannesburg residents.

VIGNETTE

Ms F is a young woman in her late twenties with an eleven year old son who lives with her mother in a township in Mpumalanga. Growing up in Mpumalanga, Ms F was able to go to secondary school but was unable to complete school because she got pregnant. And, although she has lived in Johannesburg for more than five years it doesn't feel like home to her. Home is in Mpumalanga and she goes back as often as she can, usually once a month. Ms F works a six day week, and seven hours a day for her employer of three years. She earns between R500 and R1000 a month, has no pension or medical aid, but makes a monthly contribution of R30 to a stokvel. She gets accommodation with her job where she lives in the house with her employer. She has a boyfriend, but like her child, he is not allowed to stay at her employers' property. However, her friends, mainly

domestic workers, can visit her and she visits them at their homes. Her other main social activity is going to an African church. When not visiting friends and being with her boyfriend, Ms F spends her time listening to the radio and watching television – her two main sources of information.

Although she has been with her partner for a while, he does get violent sometimes and has pushed her around and hit her. She has also had to have sex with him when she didn't want to because she was afraid of what he might do if she didn't. Ms F does not want to get pregnant and says she uses condoms for contraception. And, although she has used condoms with her boyfriend she says that what happens is that she starts the relationship using condoms and then stops using them. And, although she does not always use condoms and has no known personal relationship with someone with HIV, she is relatively well informed around HIV and AIDS related issues.

USE OF HEALTH CARE SERVICES

Usage of health care services suggests that, overall, this relatively healthy cohort of women can find health services if they need them. The majority choose to use allopathic health services for their health problems. Almost a third had been to see a doctor in the year prior to their interview. Almost 50% had been to a clinic and 15% had been to hospital outpatients (Table 26).

Family planning services and clinics were the venues of choice for getting assistance with sexual or reproductive health issues. Almost 30% of the sample had attended a family planning service in the six months prior to the interview although less than 4% had had a baby in the previous year. The South African Demographic and Health Survey 2003 reported that 66% of women of child bearing age were using contraceptives at the time of the survey.

The South African Government estimates that over 80% of people in South Africa seek help from traditional healers. As a result, efforts have been made to establish a regulated body for traditional healers. However, this study found that only just over 15% of the women had been to a traditional healer in the previous year. Of those who used traditional healers, 37% went for help with illness and a further 11% went to keep healthy. Of those women who had been for help with a health problem, almost half (47%) had also been to a doctor, clinic or hospital for the same problem. However, a significant proportion of the women

Table 26: Use of Health Care Services (%)					
	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Visited GP/doctor in past year	44.1	31.4	25.8	30.6	31.5
Average number of visits to GP	2.0	1.0	2.0	1.0	1.5
Visited clinic in past year	58.8	45.0	50.1	45.9	46.8
Average number of visits to clinic	4.0	4.5	3.8	4.4	4.4
Visited hospital outpatients in past year	10.3	14.1	15.2	14.3	14.1
Average number of visits to hospital outpatients	4.0	3.9	6.1	4.3	4.0
Visited traditional healer in past year	16.2	16.1	9.9	15.2	15.3
Average number of visits to traditional healer in past year	3.0	3.1	3.5	3.2	3.1
Visited dentist in past five years	39.7	32.8	45.0	34.6	35.3
Attended family planning service in past six months	44.1	30.3	21.2	29.0	29.8
Had a baby in the past year (%)	1.5	4.1	2.6	3.9	3.7
N=1100					

Table 27: Reasons for Using Health Care Services (%)			
	Doctor/GP (N=399)	Clinic (N=603)	Hospital (N=175)
Cough/cold/flu/chest infection	25	19	9
Chronic condition	15	22	26
Joint/bone/arm/leg/back problem	19	11	16
Sexual or reproductive health	10	19	9
Other infections	6	4	7
Generally unwell	4	3	3
Other	21	22	30

who used traditional healers went for help in other areas. Over a third (38%) went for protection, good luck, wealth, or for help in relationships. Two women had been to put a spell on someone else. It does seem that traditional healers are seen primarily for issues other than curative health. When asked where they would first seek help if they had a serious health problem, only nineteen of the women said they would go to a traditional healer.

What is the cost of using health services and who usually pays? Only thirteen of the women interviewed were members of medical aid schemes, which would enable payment for private medical services. So, most would have to pay for private health services themselves. Very few employers (15) assisted with payment for medical treatment. Payments by domestic workers for health services suggest that state services are the most affordable, and private doctors the least (Table 28). Those who saw private doctors either had medical aid and or were likely to get assistance from their employers. The low usage of traditional healers may have something to do with cost. Respondents reported the cost often exceeded R100 and three women had paid traditional healers between R1,000-3,000.

Table 28: Average Payment for Health Services (%)

	R0	R1-20	R21-40	R41 and above
Clinic (N=581)	98.1	0.9	0.2	0.8
State hospital (N=201)	17.9	62.7	16.0	3.5
Private doctor (N=293)	3.8	0.6	0.6	93.3
Family planning (N=322)	97.5	1.5	0.6	0.9
Traditional healer (N=156)	5.8	17.3	16.7	58.3

VIGNETTE

Mrs G is in her late forties. She has one adult child, but has separated from her husband and now has a new partner who she does not live with. Mrs G originally comes from a rural area in the North West where she only was able to complete primary school. Her child

and her partner live elsewhere in Johannesburg, so she is able to see them regularly even if they cannot stay with her where she lives on her employer's property. The rest of her family still live in the North West and she can only go back there once a year. And, she says that is where she would really like to live if she could find work there. She provides financial support to her child and two siblings in the North West when she can. When not seeing her family Mrs G says she works most every day of the week, for long hours, but she eams less than R1,000 a month. She has lived in Johannesburg for more than five years and has worked for her employer for as long. Although Mrs G has friends and family in Johannesburg, and, because her friends are mainly domestic workers and neighbours, she is able to see them regularly whether at church, their homes. in the street or at the shops. She goes to the shebeen to meet friends every so often. Despite her seemingly busy social life Mrs G says she often feels lonely. Her loneliest times are when she is at work and in the evenings as she says there is no-one at home. And, although she sees her partner more than once a month and her friends once a week, most of her leisure time is spent alone where she watches television and reads. Friends are her most important source of information, followed by newspa - pers and the television. Mrs G has to visit the hospital outpatients once a month because of her chronic problem with high blood pres - sure. She has been with her current partner for a couple of years. She has used a condom, but does not use one regularly – she finds she uses them with some men and not others, even though she has cared for and supported a family member with AIDS. Her irregular con - dom use has made her fearful that she may have been exposed to HIV by having unprotected sex. However, perhaps because of her fear, Mrs G is not sure if she wants to be tested for HIV, even though she knows where she could go to be tested. Although she knows about safe sex and has cared for someone with AIDS, she did not know about antiretroviral treatment or other HIV/AIDS related issues. She does however talk to family and friends about how to protect them - selves from HIV and despite her problems with her blood pressure, it remains her biggest fear for her health.

HIV/AIDS, SAFE SEX AND THE USE OF CONDOMS

CONTRACEPTIVES AND CONDOMS

As noted above, over 70% of respondents have children. Over 90% of those have received antenatal care from a doctor or clinic for their last pregnancy. A significant proportion have also attended family planning services in the six months prior to interview and/or have been to a clinic or doctor for sexual or reproductive health issues. Yet, the majority said they are not using contraceptives, and do not seem to be receiving or following any advice around the use of condoms. So, while only 11% of respondents wanted a child at the time of interview, less than 40% were using anything to delay or avoid pregnancy. Only 12% of the women used condoms for contraception (Table 29).[31]

Table 29: Methods to Delay/Avoid Pregnancy (% multiple responses)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Cannot have a baby	0.0	0.5	2.0	0.7	1.0
Injection	47.6	40.6	41.2	40.7	41.0
Oral contraceptive pill	32.4	29.0	13.7	27.2	28.0
Inter-uterine device/ loop	5.9	1.6	9.8	2.6	3.0
Sterilization	2.9	12.9	21.6	14.0	13.0
I buy pills or medicine from the chemist	0.0	0.8	0.0	0.7	1.0
Condoms	11.8	11.8	9.8	11.6	12.0
Traditional medicines	0.0	0.5	2.0	0.7	1.0
Other	0.0	0.0	0.0	1.9	2.0
N=458					

It could be that many of these women may not need to use contraceptives or to protect themselves from sexually transmitted infections (STIs) by using condoms because they do not have active sex lives. Many live apart from their partners, only seeing them irregularly, and over 40% were single (although some of these women did say they had boyfriends).

Respondents were asked how many sexual partners they had had in the past five years and on average they had slept with just 1.7 men. Thirty percent had had two or three sexual partners (Table 30). In addition, 24 had between six and ten sexual partners and two women had seventeen or more partners. Overall, just over half (52%) were in an ongoing sexual relationship with their main partner. Some 46.5% said the relationship had ended and would never be resumed, while a small percentage said they would have sex with the man if they happened to meet up.

Table 30: Number of Sexual Partners in the Last Five Years (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
None	7.4	11.5	13.3	11.4	11.2
One	51.5	48.9	45.7	48.4	48.9
Two	22.1	17.9	16.6	17.7	18.2
Three	8.8	12.5	9.3	12.1	11.9
Four or more	7.4	7.9	13.5	8.7	8.6
N=1092					

Although the majority of the domestic workers appear to have only one partner, only a quarter with long term partners or husbands actually live with them. Women who live with partners may still be at risk for HIV infection or infection with other STIs if they or their partners are unfaithful and do not have safe sex with other partners. Those who live separately from their partners may be at risk if either they or their partners are unfaithful and have unsafe sex with their other partners.[32]

South Africa has very high rates of sexual violence and domestic abuse. Studies have indicated an association between sexual violence and HIV.[33] The relationships that women have may be violent, and over 80% of women said that they had been pushed, shoved, slapped and/or had things thrown at them. Some, 18% of all respondents had been assaulted in the previous year. And, although just over half of those said it happened only once, almost 30% said it had happened a few times, and 18% said it had happened many times. Three of the women had been assaulted by their employer (all South Africans). Fewer women reported that someone had threatened to use a gun, knife or other weapon against them (10%). It is unclear whether these threats came from partners or other people.

Not altogether surprisingly in the South African context, almost 6% of participants, or 64 women, said that they had been raped. And 6%, or 66 women, had been forced to have sex with their current boyfriend, husband or other partner because they were afraid of what he might do

if they refused. One woman said she had been sexually assaulted by her employer. These figures are consistent with national data, indicating that domestic workers are not at greater risk of violence than other women in the general population but are no more protected either.[34]

Perhaps reflecting their less restricted lives, South African non-migrant women were more likely than migrant women to have been assaulted in the previous year (26%). They were also more likely to have been raped (13%) or forced to have sex by a partner (9%).

Levels of violence reported by women in long-term relationships suggest that it may be difficult for women to negotiate condom use in their relationships.[35] Given that most domestic workers live apart from their partners, condom use may be particularly important to protect them from infection. Disturbingly, their use of condoms in sexual relationships was low, and lower than among young women in South Africa.[36]

Over 60% of the women had never used a condom in their lives.[37] Of those who had used condoms, almost 30% had never used a condom with a new partner (Table 31). Of those who had used a condom in the past, only 71% had used one the last time they had sex.[38] Only 65% had used one the time before that. So, it seems that condom use is somewhat haphazard (Table 32). Only 20% of these domestic workers who used condoms used them all the time. Others said that they used condoms with some men and not others, while some said that they start with condoms and then stop using them.

Table 31: Condom Use (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Used a condom with a new partner first time had sex (N=427)	59.3	69.3	65.3	68.8	69.1
Used a condom last time had sexual intercourse (N=430)	74.1	70.7	69.4	70.5	71.2
Used a condom the time before that (N=429)	66.7	64.5	61.2	64.1	64.8
N=430					

Some of those who had used condoms but who were not using them regularly had only ever had one partner (27% of condom users). While monogamy can be seen as protection from HIV infection, it may be less effective if the partner is not faithful. Living separately from their partners may also encourage sex with multiple partners.[39]

Table 32: Condom Use in Past Three Years (%)					
	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Yes, I use them with some men and not others	29.6	34.4	34.7	34.4	35.0
I use condoms with all men all the time	18.5	19.7	18.4	19.6	20.0
Yes, start with condoms then stop using them	14.8	13.2	24.5	14.6	15.0
Never used condoms with anyone in past three years	0.0	1.7	2.0	1.7	1.7
Only had one partner ever	37.0	26.5	18.4	25.5	27.1
N=420					

Less than a quarter of respondents did anything to protect themselves against contracting an STI. Of the 251 women who did something, the majority said they used a condom (60%), had only one sexual partner or did not "sleep around" (16%). Others said they abstained from sex (20%). A few used traditional medicine (Table 33). Only 12% of the women interviewed did not know where to get condoms.

Table 33: Protection from STIs (%)					
	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Use a condom	70.0	55.1	37.0	53.2	59.8
One sexual partner/ boyfriend only	15.0	16.5	14.8	16.4	13.5
Do not sleep around	0.0	1.7	11.1	2.7	2.0
Abstain from sex/ no sexual partner	15.0	19.5	29.6	20.5	20.3
Use traditional medicine (drink muti)	0.0	1.3	3.7	1.5	1.6
Healthy lifestyle/ take care of myself	0.0	0.4	0.0	0.4	0.4
Avoid high risk areas	0.0	0.4	0.0	0.4	0.4
I had an AIDS test done	0.0	0.4	0.0	0.4	0.4
N=251					

VIGNETTE

Mrs H lost her husband at a relatively young age, as she is a widow but is only in her mid-thirties. She has two children under ten years who live with her mother in a rural area of Lesotho. Although she was able to go to secondary school she has not been able to find less demanding and more lucrative employment. Mrs H has no choice but to leave her children with her mother in Lesotho as her children are not allowed to live with her. She does try to send money home, but it is difficult because she eams less than R500 per month. This means she can only see them once a year as she does not have money or time to visit them more often. This is hard as she misses her children and would really like to be living back at home in Lesotho if she could only find work there. Mrs H is new to Johannesburg and has only lived in the city for about a year. She works hard for her wages, working nine hours a day for six days of the week. She does get food and accom - modation with her employment which helps to stretch her wages. When she finishes her day's work, she crosses the yard to her room where she has access to hot and cold running water. Mrs H does not have a South African ID book, and is very scared that she might be arrested and deported for being a foreigner. But, so far she has not had any bad experiences in South Africa as a foreigner. Mrs H had friends in Johannesburg before she arrived in the city and has made friends among neighbouring domestic workers. Although they are not allowed to visit her at her home, she is able to see them once a week at their homes. Although Mrs H says she doesn't feel lonely most of the time even though she spends most of her leisure time alone, she does miss her children and would like to have a boyfriend.

She does not want to get pregnant, and when in a relationship says she uses condoms for contraception. Mrs H is relatively knowledge - able about HIV and AIDS and says she always uses a condom when she has sex. Her commitment to condoms may reflect her personal experience of HIV as she has cared for and supported a family mem - ber with AIDS. And, although she does not think that she has ever been exposed to the virus, she says she would take a test if she knew where to get one for free and that would be confidential.

KNOWLEDGE OF HIV/AIDS

Low use of condoms for protection can only be partially explained by abstinence, monogamy, lack of access to condoms, or abusive or unbalanced relationships. Although the majority of the women interviewed spent most of their leisure time watching television and listening to the radio, they did not seem to be taking on board HIV education and prevention messages and information available through the media. Furthermore, a significant proportion had given birth to children in the past and used family planning services in the previous six months, while others had attended other health services. In theory, they should have had relatively good knowledge of at least some HIV/AIDS issues from health care providers.

Participants were asked if they had heard of a variety of issues relating to HIV/AIDS and whether they could explain what they were (Table 34). Over 30% could not explain or describe how to have sex safely. If people do not understand the importance of safe sex, or how to have sex safely, they are unlikely to be able to protect themselves or ask their partners to wear a condom.

Although over a quarter of South Africa's adult population is infected by HIV and women (because of childbirth, ante-natal care and use of family planning facilities) are likely to have come into contact with health care workers and may even have been tested for HIV, only 45% of respondents knew about mother-to-child transmission (Table 34).

The domestic workers also showed relatively low knowledge about HIV treatment issues (Table 34). So, only 16% could explain what anti-retroviral treatment is and only 20% could explain treatment for opportunistic infections. Their lack of knowledge around issues related to treatment is surprising as a significant proportion of participants said HIV/AIDS had touched their lives in intimate ways. Also, the survey took place at a time when there was considerable debate in the media around treatment for AIDS and the roll-out of anti-retroviral treatment.

So, while there have been a number of campaigns around HIV/AIDS education, prevention and treatment, as well as integration of these issues into popular locally produced soap operas and dramas, it seems that this group, who watch television and listen to the radio, are not being reached by these campaigns. As some commentators have noted, behavioural approaches to behaviour change are often inadequate as they ignore the context within which people live and have to negotiate behaviour change. They suggest a need to take into account issues of power, poverty and gender relations in people's social and working lives to better understand how to enable people to act on information received, and even to receive the information in the first place.[40]

Table 34: Ability to Correctly Explain Term (%)					
	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Mother to child transmission of HIV?					
Correct	36.8	44.0	55.6	45.7	45.1
No	45.6	41.1	29.1	39.4	40.0
Incorrect	17.7	14.8	14.6	14.8	14.9
Safe sex?					
Correct	64.7	67.5	78.2	69.1	69.1
No	26.5	23.7	15.2	22.5	22.9
Incorrect	8.8	8.1	6.6	7.9	8.0
AIDS vaccine?					
Correct	19.1	12.8	17.9	13.5	14.0
No	63.2	62.6	51.7	61.0	62.0
Incorrect	16.2	23.5	29.1	24.3	24.0
Anti-retroviral treatment?					
Correct	17.7	14.9	22.5	16.0	16.2
No	66.2	61.7	49.0	59.9	60.9
Incorrect	16.2	22.4	27.2	23.1	22.8
Traditional AIDS cures/ African potato?					
Correct	33.8	38.3	56.3	40.9	40.9
No	53.0	45.7	25.2	42.7	43.6
Incorrect	11.8	15.5	16.6	15.7	15.5
Treatment for TB?					
Correct	38.2	40.6	50.3	42.0	42.3
No	48.5	41.7	33.8	40.5	41.7
Incorrect	11.8	16.3	14.6	16.0	16.0
Treatment for opportunistic infections?					
Correct	22.1	17.2	25.8	18.5	19.3
No	55.9	58.8	42.4	56.4	58.0
Incorrect	11.8	21.9	28.5	22.8	22.8
N=1100					

ASSESSMENT OF VULNERABILITY

Notwithstanding their lack of knowledge around HIV/AIDS issues, the virus had touched the lives of these domestic workers; sometimes on a very personal level. Participants in the study were asked if they had ever been tested for HIV and the results of their tests (Table 35). Less than a third of participants, or only 296 women had been tested.[41] Only 10% of those tested positive (26 women).

Table 35: Tested for HIV and Results (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Tested for HIV: I am positive	3.0	2.1	4.0	2.3	2.4
Tested for HIV: I am negative	19.7	22.5	18.8	22.0	22.4
Tested for HIV: Do not know results	4.6	2.5	4.7	2.8	3.0
Never tested: but I think I have HIV	3.0	0.9	2.0	1.1	1.2
Never tested: do not know my HIV status	62.1	70.1	67.1	69.6	71.0
Not answered	7.6	1.9	3.4	2.2	2.6
N=1097					

Knowing someone who is HIV positive or has died of AIDS often pushes people to take the problem of HIV/AIDS more seriously.[42] Many of the domestic workers interviewed had been touched by HIV/AIDS in other ways: knowing people who have died of AIDS, having family members with AIDS and caring for or supporting people with AIDS (Table 36).

Table 36: Experiences with People with HIV/AIDS (%)

	Total non-South Africans	South African migrants	South African non-migrants	Total South Africans	Total sample
Know anyone who you think has died of AIDS (N=1098)	36.8	33.4	60.3	37.3	37.3
Anyone in family with AIDS or died of AIDS (N=1096)	16.2	16.6	37.1	19.6	19.4
Cared for or supported someone with AIDS (N=1100)	14.7	15.6	29.8	17.7	17.5

Perhaps reflecting their day-to-day connections with their urban community and wider social networks, non-migrant domestic workers had significantly more personal experience of HIV/AIDS. So, although only a third of South African migrants knew someone who had died of AIDS, almost two-thirds of non-migrants said the same. Similarly, the proportion of migrants who knew of a family member who was living with, or who had died of AIDS, was less than half that of non-migrants. Again, non-migrants were twice as likely to have cared for or supported someone with AIDS.

Although some women had been tested for HIV/AIDS, the majority had not. Attitudes to testing were mixed. A significant proportion of participants (71%) said they would be willing to take a test if it was offered in secret and free of charge. As tests are offered in secret and free of charge at many clinics and hospitals in South Africa, it is not clear why these women do not know that, or if they do, have not taken the opportunity to be tested. Poor service delivery, long waiting times or lack of access to anti-retroviral therapy may explain the low uptake of voluntary counselling and testing.

The lack of interest in being tested may, in part, be a consequence of the participants' rather sanguine attitude to their potential vulnerability: over 80% of respondents thought they had not been exposed to HIV and only 11% thought they might have been. However, over 20% said that their foremost health worry was becoming infected.

Overall, respondents showed that they were concerned about HIV/AIDS and would not be hostile to anyone close to them who had AIDS. However, this cohort of women workers living in Johannesburg show low levels of condom use in the face of the risks that they face as single women with active sex lives or as women with partners living elsewhere. Their responses suggest that they are not receiving health education messages, and if they are, are not acting on them.

VIGNETTE

Ms J is in her mid-thirties. She is a single mother of three children aged 21, 16 and 10. Unfortunately she was unable to complete primary school when she was growing up in a township in the Northern Cape. Her children live with her mother as she is not allowed to have them stay with her where she is living, but she does try to provide money to support them. She goes

home to see them around once a month. Ms J arrived in Johannesburg around five years ago. Unemployed, she made the decision to go to Johannesburg alone and was not influenced by family members. Ms J had family members in Johannesburg before she arrived in the city who were able to provide her with a place to stay. She does not think of Johannesburg as home. Although she goes home often, Ms J is now perhaps an embedded migrant worker as she says she would not live in the Northern Cape even if she could find a similar job there. Ms J has been working for her employer for nearly five years. She works for only one employer, but works six days a week and for eight hours a day on average. For her 48 hour working week, she earns less than R500 per month (below the statutory minimum wage and above statutory maximum working hours without overtime). However, she does receive some food as part of her pay and does not have to pay for her accommodation on her employer's property. She is not a member of a medical aid scheme, has no pension plan and, she is not a member of a stokvel or similar savings scheme. She lives in only one room and has no access to a bathroom with running water and has to go outside to a tap to get water. She does have electricity in her room. She has no access to a telephone so she can't call home, even if she wanted to. Ms J says she rarely feels lonely as she has friends among the neighbouring domestic workers. Because they live close by, she is able to see them often during the week, usually at their home as her friends are not allowed to visit her where she works. Her loneliest hours are when she is working because, as she says, it lets her "think too much." Ms J is not a churchgoer and most of her non-working time is spent alone listening to the radio (her major source of information), although she does see the neighbouring domestic workers. She is a hopeful woman, playing lotto. Ms J has relatively good health, has never smoked, and does not use snuff, alcohol or other drugs. She has been to the clinic three times in the past year to deal with sexual and reproductive health issues. She would use a range of health service providers depending on the problem; so, if she thought she had broken a limb or started to lose a lot of weight, she would choose to go first to a traditional healer. For other problems she would go first to see a doctor. Ms J does not want to get pregnant and uses an injection to prevent pregnancy. She has had one sexual relationship in the past five years which has ended and which she would not resume if she was to meet him again. She has not experienced violence inside or outside her relationships. To the best of her knowledge she does not know anyone who has HIV or has

died of AIDS. Although she knows where to get condoms for free she has never used a condom in her life. And, although she doesn't think she has been exposed to HIV (despite her lack of condom use) she would like to be tested, but doesn't know where she could go to get a free test which would be confidential. When asked to explain various issues around HIV/AIDS, she did know how to protect herself sexu - ally (again despite her lack of condom use), but did not know about mother to child transmission, anti-retroviral treatment, or treatments for TB and opportunistic infections. She does talk about HIV with her family.

CONCLUSION

So, how do migrancy, work, health and HIV/AIDS intersect in the lives of domestic workers living in Johannesburg? And what are the implications of this study for domestic workers and health service providers?

First, the study demonstrates that migrancy is a defining feature of the lives of the majority of this cohort of domestic workers. It shapes their lives and relationship in many ways. Many, though they have lived in Johannesburg for a long time, and see it as a home, are constantly looking to a home elsewhere where their children, and sometimes their partners, live. Over 40% of the sample described themselves as single, widowed, divorced or separated (although this did not prevent them from having children and boyfriends). Further research is needed to understand whether being single provides an incentive for women to migrate for work.

As migrant workers, many live in accommodation provided by their employers. Restrictions imposed by employers prevent them being joined by their children, partners and boyfriends. Only a quarter of the women interviewed live with their partner. While living with a partner does not prevent people from having multiple relationships, it does reduce the likelihood.

Second, working conditions are hard. The women work long hours and long working weeks for low pay. Despite attempts by the Government to improve the working conditions of domestic workers, many employers pay under the minimum wage and require their employees to work over the maximum working hours. Most only have access to one room, and the majority of those who live off their employers property are living in shacks. Only a third have access to a bathroom

with running water and almost half have to go outside to get water. While none of this necessarily increases their vulnerability to HIV infection, low incomes and poor living conditions do have implications for people who are living with the virus as these conditions may compromise their health status.

Working and living conditions, particularly for those that live-in, appear to provide some protection to domestic workers as they limit their opportunities to socialise with friends and meet new partners. It seems that many live restricted lives as most of their friends are likely to be neighbouring domestic workers who they meet at their homes or in the street. Church provides another significant opportunity for social interaction. Otherwise, the majority of this cohort of workers spend most of their few leisure hours alone watching television and listening to the radio.

Third, the study shows, contrary to our original expectations, that the majority of these women, whatever their migrant and national status, do not have problems accessing health services. The majority use allopathic health services provided by the state. Traditional healers are used only by a few. And almost half of those who use a traditional healer for health issues also go to allopathic services for the same problem. They do not seem to have any health problems particular to their work, and perhaps their isolation in the workplace reduces their opportunities to catch infectious illnesses like flu and colds.

Fourth, despite their use of health services, the majority of these women do not appear to be protecting themselves from HIV infection. A defining characteristic of this group is the lack of condom use. Over 60% of the sample had never used a condom in their lives. Also disturbing is that the majority of those who used condoms used them irregularly with only a fifth of condom users saying they used condoms all the time when they had sex. Low levels of condom use may also reflect experiences of violence in relationships.

Fifth, this cohort of women workers do not seem to be being reached by health promotion campaigns, or they are just not listening. Low levels of condom use may be related to low levels of knowledge around HIV/AIDS issues, including safe sex as well as confidence regarding their vulnerability. So, almost a third were unable to describe how to have safe sex and only 11% thought they might have been infected. Levels of knowledge around treatment issues were also low and only 16% knew about anti-retroviral therapy. Low levels of knowledge around antiretroviral treatment and the fact that it had yet to be introduced in public health services in the Johannesburg area may have affected attitudes to testing. Less than a third had been tested for HIV and only twenty-six women in the sample had tested positive. Further

research is necessary to find out whether the effectiveness of campaigns which encourage voluntary testing and counselling will be increased with the roll-out of antiretroviral treatment.

Sixth, low levels of knowledge and condom use are inconsistent with the experiences of these women with the virus. Many have been touched by HIV/AIDS in their lives. Over a third knew someone who had died of AIDS; a similar proportion said a member of their family was HIV positive or had died of AIDS; and almost a fifth had physically cared for or supported someone with AIDS. Probably reflecting their closer connections to their communities and wider social networks, non-migrant women were most likely to know someone with HIV/AIDS and to have cared for someone with AIDS.

Overall, it seems that migrancy and work shape these women's lives and affect their vulnerability to HIV. It seems that for many, particularly those who live-in on their employers' property, their social lives are restricted by their working and living conditions. This social isolation may actually protect these domestic workers as it reduces opportunities for starting new relationships. Unlike many other migrant workers, it seems that the live-in status of many migrant domestic workers, and their working conditions, may mean that their opportunities to become infected by the virus could be less than their non-migrant counterparts. However, this does not mean that they are not vulnerable. And, conversely, their migrant status, separation from partners, and for many, restrictions on when and where they can see their partners and boyfriends may make them more vulnerable.

The low levels of condom use, given the circumstances of their relationships and low levels of knowledge around issues related to HIV/AIDS, are of concern. The majority of these women look to television and listen to the radio to get information. The majority attend health services at some point during the year. Therefore, it seems that this cohort of women workers in Johannesburg are not being reached by health promotion campaigns relating to HIV/AIDS education, prevention and treatment. And, it may be that their isolation, socio-economic circumstances and the lack of power in their working lives affects their ability and willingness to act on the information they have.

ENDNOTES

1 Jonathan Crush, Brian Williams, E. Louw and Mark Lurie, *Spaces of vulnera - bility: Migration and HIV/AIDS in South Africa*, SAMP Migration Policy Series, No. 24, Cape Town, 2002; Mark Lurie et al. 2003. "The impact of migration on HIV-1 transmission in South Africa," *American Sexually Transmitted Diseases Association*, February (2003): 149-155; K. Zuma, E. Gouws, Brian Williams, and Mark Lurie, "Risk factors for HIV infection among women in Carletonville, South Africa: migration, demography and sexually transmitted diseases," *International Journal of STD & AIDS*, 14 (2003): 814-817; Mark Lurie, *Migration, sexuality and the spread of HIV/AIDS in rural South Africa*, SAMP Migration Policy Series, No. 31, Cape Town, 2004.

2 Crush et al, *Spaces of vulnerability*; Lurie et al, "The impact of migration on HIV-1 transmission"; Zuma et al, "Risk factors for HIV infection"; Lurie, *Migration, sexuality and the spread of HIV/AIDS.*

3 Ibid.

4 Ibid.

5 Ibid.

6 Ibid.

7 Lurie et al, "The impact of migration on HIV-1 transmission"; Zuma et al, "Risk factors for HIV infection among women in Carletonville"; Lurie, *Migration, sexuality and the spread of HIV/AIDS*.

8 Belinda Dodson, "Women on the move; Gender and cross-border migration to South Africa from Lesotho, Mozambique and Zimbabwe," in David McDonald (ed.) *On Borders*, (Kingston and New York: SAMP and St Martins Press, 2000), pp. 119-150.

9 See, Camilla Cockerton, "Documenting the exodus: The dimensions and local causes of Bechuanaland women's migration to South Africa, 1920-1966," *South African Geographical Joumal*, 79 (1997): 43-51; Miranda Miles, "Migration and development in post-colonial Swaziland: a study of women's mobility and livelihood strategies," unpublished Ph.D. thesis, University of the Witwatersrand (1996); Miranda Miles, "Missing women: a study of Swazi female migration to the Witwatersrand, 1920-1970," unpublished M.A. the-sis, Queen's University (1991).

10 Statistics South Africa, "Labour Force Survey, September 2004," Pretoria: Statistics South Africa (2005): 19-20. The largest sector of employment for black women is the wholesale and retail trade, which employed 848,000 women in 2004. The third largest sector is community, social and personal services, which employed 709,000 black women in 2004. A national survey of 982 domestic workers undertaken in 2000 found that 59% were employed in metropolitan areas, 37% in small urban areas and 3% on rural farms and homesteads (Community Agency for Social Enquiry (CASE), "Results of the

survey on domestic workers and employers," unpublished report, 2001).

11 Census 2001, unpublished data kindly supplied by Statistics South Africa.

12 For a similar study in the Nigerian context see: A. Akinrimisi, "Appreciating the Plight of Domestic Workers," *Women's Global Network for Reproductive Rights*, Newsletter 78, (March 2003).

13 One hundred enumerator areas were originally randomly selected from the Johannesburg Magisterial District. Six had to be excluded as they did not contain forty households living in houses.

14 It is possible, if not probable, that areas lying outside the JMD which show low rates of employment of domestic workers, in effect have higher rates of employment than shown in the Labour Force Survey as households may use the term 'helper' and/or family members carry out the duties of domestic workers.

15 Over 57% of households in the City of Johannesburg live in such houses (Census 2001, Statistics South Africa, http://www.statssa.gov.za).

16 The Community Agency for Social Enquiry interviewed domestic workers in enumerator areas with average incomes over R1,500 per month and included flat dwellers and metropolitan, small urban and rural areas, found 36% of domestic workers lived-in. (Community Agency for Social Enquiry, "Results of the survey on domestic workers").

17 Census 2001, Statistics South Africa. Some Census data is available on http://www.statssa.gov.za while other unpublished Census 2001 data was kindly provided by Statistics South Africa.

18 Ibid.

19 Given the small sample size of cross-border migrant domestic workers it is difficult to identify significant differences in their profiles from internal migrants or non-migrants.

20 South African Human Rights Commission (SAHRC), "Report into the Arrest and Detention of Suspected Undocumented Migrants," (Johannesburg: SAHRC, 1999).

21 An amnesty for SADC undocumented nationals in 1996 gave some the opportunity to obtain permanent residence and ID books. See: Jonathan Crush and Vincent Williams, eds.. 1999. *The New South Africans? Immigration Amnesties and their Aftermath* (Cape Town: Southern African Migration Project, 1999).

22 The CASE survey found 24% were aged between 16-30 years, 31% between 31-40 years; 30% between 41-50 years and 2% were over 61 years in age (Community Agency for Social Enquiry, "Results of the survey on domestic workers").

23 Separated children were most likely to be cared for by their grandmother.

24 Census 2001 data for Johannesburg suggests that domestic workers are slightly less educated than other women in the city. It shows that of women living in the city, 8.7% of South African born, and 8.3% of SADC born in the city

have no schooling; 25.7% of South Africans and 21.2% of SADC born have some/completed primary school; 56.1% of South Africans and 54% of SADC born have some/completed secondary school; and 11.1% of South Africans and 16.4% of SADC born have some tertiary education (Census 2001, unpublished data supplied by Statistics South Africa). The CASE national survey showed similar levels of education to this study (Community Agency for Social Enquiry, "Results of the survey on domestic workers).

25 See the website of the Department of Labour: http://www.dol.gov.za. See also C. Hardy and A. Kleinsmidt, *HIV/AIDS and the workplace: Your RIGHTS as a domestic worker: HIV and the law*, (AIDS Law Project: Johannesburg, 2004).

26 See the website of the Department of Labour: http://www.dol.gov.za.

27 The CASE survey found that only 36% of respondents lived in and 82% worked for only one employer (Community Agency for Social Enquiry, "Results of the survey on domestic workers").

28 The September 2004 Labour Force Survey found that nationally (including rural areas), 41.2% of domestic workers earned between R1-500; 40.9% between R501-R1,000; and 13.2% between R1,001-2,500 (Statistics South Africa "Labour Force Survey, September 2004," pp. 23).

29 Just over half attended indigenous churches, and 4% went to mosque or temples to worship, the remainder attended mainstream churches.

30 Registered refugees and asylum seekers should be able to access government health facilities at the same rates as South African nationals.

31 A study of the use of condoms as contraceptives found they were used by 15% of married couples in South Africa (cited in Warren Parker, "HIV/AIDS and behaviour change in South Africa: Implications of recent findings" unpublished presentation, Centre for AIDS Development, Research and Evaluation, 2004).

32 Lurie, *Migration, sexuality and the spread of HIV/AIDS.*

33 United Nations Secretary-General's Task Force on Women, Girls and HIV/AIDS in Southern Africa. 2004. "Facing the Future Together," Geneva: United Nations.

34 Rachel Jewkes et al, 2001. "Prevalence of emotional, physical and sexual abuse of women in three South African Provinces" *South African Medical Journal*, 91:5 (2001): 421:428.

35 Ibid.

36 Parker, "HIV/AIDS and behaviour change."

37 Data on the use of condoms by youth aged between 15 and 24 has found a significant increase in condom use in the past ten years. Data on condom use for young women aged 15-24 years from a variety of surveys was was at 20% in 1996; 30% in 1998; 68% in 2002 and over 80% in 2003 (cited in Parker, "HIV/AIDS and behaviour change").

38 Data from other studies with youth aged between 15-24 found lower rates of use of condoms when respondents were asked if they had used a condom the

last time they had intercourse: 45% in 2002 and 55% in 2003 (Parker. "HIV/AIDS and behaviour change.")

39 Lurie et al, "The impact of migration on HIV-1 transmission"; Zuma et al, "Risk factors for HIV infection among women in Carletonville."

40 Parker, "HIV/AIDS and behaviour change."

41 Intermittently the South African press carries reports of employers coercing, or secretly having, domestic workers tested for HIV (see for instance *The Star*, 19 May 2002). However, interviewees did not report such cases.

42 Parker, "HIV/AIDS and behaviour change."

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